



Developmental History Information

I. Student Information:

Student Name: _____ DOB: ____/____/____ Grade: ____
Teacher: _____ School: _____
Parent(s)/ Guardian: _____

II. Family Information:

What are your child's strengths? _____

What concerns do you have for your child? _____

In what language did your child first learn to talk? _____

If English is 2nd language, how long has your child spoken English? _____

What language is primarily spoken at home? _____

Major Life Events Experienced by Your Child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Divorce of Parents | <input type="checkbox"/> Death of a Close Family Member | <input type="checkbox"/> Major Illness |
| <input type="checkbox"/> Home Dislocation | <input type="checkbox"/> Home Fire | <input type="checkbox"/> Natural Disaster |

Is there any other major life event experienced by your child that you think may have had an impact on your child? _____

III. Medical History:

Child's physician _____ Physician phone # _____

Check any of the following complications that occurred during the pregnancy:

- | | | | |
|--------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> RH incompatibility |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Low Oxygen | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Other _____ | | | |

Has this child ever had any serious illnesses, accidents, or head injuries? ☐ Yes ☐ No

If "yes", please explain: _____

Has this child ever experienced problems in the following areas?

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> walking | <input type="checkbox"/> temper tantrums | <input type="checkbox"/> underweight/ overweight | <input type="checkbox"/> unclear speech | <input type="checkbox"/> failure to thrive |
| <input type="checkbox"/> hearing | <input type="checkbox"/> vision | <input type="checkbox"/> sleep problems | <input type="checkbox"/> eating problems | <input type="checkbox"/> does not speak |
| <input type="checkbox"/> fine motor skills (handwriting, tying shoes, etc) | | | <input type="checkbox"/> Difficulty making friends | |
| <input type="checkbox"/> gross motor skills (running, riding bike, skip, etc) | | | <input type="checkbox"/> Other | |

If any of the above are checked please specify: _____

Please indicate any illness this child has experienced:

- | | | | | |
|-------------------------------------|------------------------------------|---|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Gastro-intestinal problems |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Any heart condition |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Verbal/ motor tics | <input type="checkbox"/> Other, please describe: _____ | |

Is this child presently on any medications? ☐Yes ☐No

If "yes", what kind? _____

Has your child ever had psychological counseling or therapy? ☐Yes ☐No

Complete the following if "Yes": Counselor's Name: _____ Phone: _____

Has this child ever had a neurological exam? ☐Yes ☐No

If "Yes", please specify: _____

IV. Educational Background:

Did this child attend preschool? ☐Yes ☐No

If "Yes", where and for how long? _____

Have any relatives had difficulties similar to those this child is experiencing? ☐Yes ☐No

If "Yes", please explain: _____

Please indicate whether this child exhibits any of the following behavior:

☐Has a short attention span ☐Has Fears ☐Overreacts when faced with a problem

☐Unhappy much of the time ☐Seems impulsive ☐Requires a lot of attention

☐Enjoys active games ☐Enjoys activities such as reading, drawing, writing, etc.

☐Needs more help with school work than others his/her age

Other: _____

Please indicate any of the following that this student has experienced in school:

☐Skipped a grade ☐Disliked going to school ☐Had frequent absences from school

☐Behavior problems ☐Emotional difficulties ☐Changed schools several times in one school year

☐Poor Grades ☐Difficulty with Math ☐Has been evaluated for special education

☐Been Retained ☐Difficulty with Reading ☐Difficulty with writing or spelling

Other: _____

V. Social History:

How does your child spend his/her free time? _____

How many close friends does your child have? ☐0-2 ☐2-4 ☐4 or more

Please indicate if your child is able to do the following [now or earlier in their development]:

☐Show good eye contact ☐engage in pretend play ☐Discuss a variety of interests

☐Initiate conversation ☐initiate play ☐Is able to adjust to changes in routine

I give permission for my child to be observed, as needed, by educational specialists (speech-language pathologists, school psychologists, hearing specialist, etc.)

Signature of person completing this form: _____

Relationship to the student: _____

Please return this form to: _____